JMHS Weekly Schedule
8/17- 8/21

Monday: 8/17
- 7:00 am- 8:30 am Morning Band Rehearsal

Tuesday: 8/18
- 5:00 pm- 8:00 pm Evening Band Rehearsal

Wednesday: 8/19
-

Thursday: 8/20
- 7:00 am- 8:30 am Morning Band Rehearsal

Friday: 8/21
- 7:00 am- 8:30 am Morning Band Rehearsal

Announcements
- This week we will start enforcing our attendance policy. Email me if you are going to miss rehearsal.
- Freshman and Juniors make sure you get your physicals taken care of before the first game on August 27th
- Brass, woodwinds, and percussion please wear white t-shirts to practice. Colorguard Mr. Schmidt will let you know what color shirts to wear to rehearsal.

Briana Freitas
Assistant Band Director
briana.freitas@nisd.net

Kevin Tabb
Director of Bands
kevin.tabb@nisd.net
210-397-7227

Daniel Bentley
Assistant Band Director
daniel.bentley@nisd.net

2026-2027 Northside ISD Medical History – BAND

X Student ID # _____

This form must be on file prior to participation in any practice or performance before, during or after school.

Student Name LAST _____ **Student Name FIRST** _____ **Grade 26-27 school year** _____ **Date of Birth** _____

Student Address (Street, City, Zip Code) _____ **Student Phone** _____ **Age** _____ **Sex** _____

In case of Emergency contact:

Name _____ **Relationship** _____ **Phone** _____ **Cell Phone** _____

This MEDICAL HISTORY FORM must be completed ***annually*** by parent (or guardian) and student in order for the student to participate in activities. These questions are designed to determine if the student has developed any condition which would make it hazardous to participate.

Explain "Yes" answers in the box below**
Circle questions to which you do not know the answer

		Yes No
1	Have you had a medical illness or injury since your last check up or sports physical?	☐ ☐
2	Have you been hospitalized overnight in the past year?	☐ ☐
	Have you ever had surgery?	☐ ☐
3	Have you ever had prior testing for the heart ordered by a physician?	☐ ☐
	Have you ever passed out during or after exercise?	☐ ☐
	Have you ever had chest pain during or after exercise?	☐ ☐
	Do you get tired more quickly than your friends do during exercise?	☐ ☐
	Have you ever had racing of your heart or skipped heartbeats?	☐ ☐
	Have you had high blood pressure or high cholesterol?	☐ ☐
	Have you ever been told you have a heart murmur?	☐ ☐
	Has any family member or relative died of heart problems or of sudden unexpected death before age 50?	☐ ☐
	Has any family member been diagnosed with enlarged heart, (dilated cardiomyopathy), hypertrophic cardiomyopathy, long QT syndrome or other ion channelopathy (Brugada syndrome, etc), Marfan's syndrome, or abnormal heart rhythm)?	☐ ☐
	Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month?	☐ ☐
	Has a physician ever denied or restricted your participation in sports for any heart problems?	☐ ☐
4	Have you ever had a head injury or concussion?	☐ ☐
	Have you ever been knocked out, become unconscious, or lost your memory?	☐ ☐
	If yes, how many times?	_____
	When was the last concussion?	☐ ☐
	How severe was each one? (Explain below)	
	Have you ever had a seizure?	☐ ☐
	Do you have frequent or severe headaches?	☐ ☐
	Have you ever had numbness or tingling in your arms, hands, legs, or feet?	☐ ☐
	Have you ever had a stinger, burner, or pinched nerve?	☐ ☐
5	Are you missing any paired organs?	☐ ☐
6	Are you under a doctor's care?	☐ ☐
7	Are you currently taking any prescription or non-prescription (over-the-counter) medication or pills or using an inhaler?	☐ ☐
8	Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)?	☐ ☐
9	Have you ever been dizzy during or after exercise?	☐ ☐
10	Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)?	☐ ☐
11	Have you ever become ill from exercising in the heat?	☐ ☐
12	Have you had any problems with your eyes or vision?	☐ ☐

		Yes No
13	Have you ever gotten unexpectedly short of breath with exercise?	☐ ☐
	Do you have Asthma?	☐ ☐
	*** If yes, complete both sides of the Asthma Action Form**	
	Do you have an inhaler?	☐ ☐
	Do you have seasonal allergies that require medical treatment?	☐ ☐
14	Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position (for example, knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid)?	☐ ☐
15	Have you ever had a sprain, strain, or swelling after injury?	☐ ☐
	Have you broken or fractured any bones or dislocated any joints?	☐ ☐
	Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints?	☐ ☐
	If yes, check appropriate box and explain below.	

☐ Neck	☐ Forearm	☐ Thigh
☐ Back	☐ Wrist	☐ Knee
☐ Chest	☐ Hand	☐ Shin/Calf
☐ Shoulder	☐ Finger	☐ Ankle
☐ Upper Arm		☐ Foot

16	Do you want to weigh more or less than you do now?	☐ ☐
	Do you lose weight regularly to meet weight requirements for your sport?	☐ ☐
17	Do you feel stressed out?	☐ ☐
18	Have you ever been diagnosed with or treated for sickle cell trait or sickle cell diseases?	☐ ☐
	Females only	
19	When was your first menstrual period?	_____
	When was your most recent menstrual period?	_____
	How much time do you usually have from the start of one period to the start of another?	_____
	How many periods have you had in the last year?	_____
	What was the longest time between periods in the last year?	_____

An individual answering in the affirmative to any question relating to a possible cardiovascular health issue (questions three above), as identified on the form, should be restricted from further participation until the individual is examined and cleared by a physician, physician assistant, chiropractor, or nurse practitioner.
**EXPLAIN 'YES' ANSWERS IN THE BOX BELOW (Attach additional sheet if necessary)

Neither the University Interscholastic League nor the high school assumes any responsibility in case an accident occurs. If, in the judgment of any representative of the school, the above student should need immediate care and treatment as a result of any injury or sickness, I do hereby request, authorize, and consent to such care and treatment as may be given said student by any physician, athletic trainer, nurse, or school representative. I do hereby agree to indemnify and save harmless the school and any school or hospital representative from any claim by any person on account of such care and treatment of said student. If, between this date and the beginning of competition, any illness or injury should occur that may limit this student's participation, I agree to notify the school authorities of such illness or injury.

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct. Failure to provide truthful responses could subject the student in question to penalties determined by the UIL

X Student Signature: _____ **X Parent/Guardian Signature:** _____ **Date:** _____

Any yes answer to questions, 1, 2, 3, 4, 5 or 6, may require further medical evaluation, which may include a physical exam. The written clearance from a Physician, Physician Assistant, Chiropractor, or Nurse Practitioner is required before any participation in UIL events.

PRE-PARTICIPATION PHYSICAL EVALUATION -- PHYSICAL EXAMINATION - BAND

Student's Name _____ Sex _____Age _____ Date of Birth _____

Height_____ Weight_____ % Body fat (optional) _____ Pulse _____ BP_____/_____ (_____/_____, _____/_____)

Brachial blood pressure while sitting

Vision R 20/_____ L 20/_____ Corrected: ☐Y ☐N Pupils: ☐Equal ☐Unequal

As a minimum requirement, this **Physical Examination Form** must be completed prior to junior high participation and again, prior to first and third years of high school participation. It ***must*** be completed if there are yes answers to specific questions on the student's MEDICAL HISTORY FORM on the reverse side. ***Local district policy may require an annual physical exam***.

	NORMAL	ABNORMAL FINDINGS	INITIALS*
MEDICAL			
Appearances			
Eyes/Ears/Nose/Throat			
Lymph Nodes			
Heart-Auscultation of the heart in the supine position			
Heart-Auscultation of the heart in the standing position			
Heart-Lower extremity pulses			
Pulses			
Lungs			
Abdomen			
Genitalia (Males only)			
Skin			
Marfan's stigmata (arachnodactyly, pectus excavatum, joint hypermobility, scoliosis)			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/Arm			
Elbow/Hand			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot			

*station-based examination only

☐Cleared

☐Cleared after completing evaluation/rehabilitation for: _____

_____

☐Not cleared for:_____ Reason: _____

Recommendations:_____ _____

The following information must be filled in and signed by either a Physician, a Physician Assistant licensed by a State Board of Physician Assistant Examiners, a Registered Nurse recognized as an Advanced Practice Nurse by the Board of Nurse Examiners, or a Doctor of Chiropractic. Examination forms signed by any other health care practitioner will not be accepted.

Name (print/type) _____ Date of Examination:_____

Address:_____

Phone Number:_____

Signature:_____

THIS FORM MUST BE ON FILE PRIOR TO PARTICIPATION IN ANY PRACTICE OR PERFORMANCE BEFORE, DURING OR AFTER SCHOOL.